

471-000-224 Instructions for Completing Form DPI-OBRA2. "Evaluation and Service Recommendation"

Use: Form DPI-OBRA2 is used to complete the first Level II evaluation for each individual who requires a Level II evaluation. Information on this form will enable the reviewer to -

1. Validate the diagnosis of serious mental illness and/or mental retardation;
2. Validate the diagnosis of a related condition; and
3. Recommend the most appropriate placement for the individual, based on the individual's medical, physical, functional, and psychosocial needs.

Number Prepared: One copy of Form DPI-OBRA2 is completed.

Completion: Form DPI-OBRA2 is completed by the mental health reviewer or QMRP as indicated on the form.

Signature: The mental health reviewer or QMRP signs and dates the form. Form DPI-OBRA2 must be counter-signed by the validating professional for cases of serious mental illness.

Distribution: The CMHR or CBDDSP sends Form DPI-OBRA2 to the HHS/Contractor within the specified time period.

Retention: Form DPI-OBRA2 is retained for four years.

DPI - OBRA 2 MI

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Name: _____

Section III: FUNCTIONAL ASSESSMENT/PLACEMENT POTENTIAL

<p>1. Vision</p> <p>___ Adequate without aids</p> <p>___ Adequate with aids _____</p> <p>___ Little or no residual capacity</p> <p>___ Other _____</p> <p>3. Communication abilities</p> <p>___ No Deficits ___ Speech with Deficits _____</p> <p>___ Gestures ___ No residual capacity</p> <p>___ Adaptive equipment _____</p> <p>5. Transfer</p> <p>___ Independent without assistance</p> <p>___ Independent with assistive devices _____</p> <p>___ Assistance of 1 or 2</p> <p>___ Immobile</p> <p>___ Other _____</p> <p>7. Bowel continence</p> <p>___ Continent</p> <p>___ Occasionally incontinent ___ Usually incontinent</p> <p>___ Inappropriately incontinent ___ Frequently incontinent</p> <p>___ On toileting schedule ___ Incontinent</p>	<p>2. Hearing</p> <p>___ Adequate without aids</p> <p>___ Adequate with aids _____</p> <p>___ Little or no residual capacity</p> <p>___ Other _____</p> <p>4. Comprehends others</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>6. Eating</p> <p>___ Independent</p> <p>___ Adaptive equipment</p> <p>___ Tube or parenteral</p> <p>___ Independent after tray set up</p> <p>___ Supervision/prompts</p> <p>___ Refuses or appetite loss</p> <p>___ On feeding program</p> <p>___ Other _____</p> <p>8. Bladder continence</p> <p>___ Continent</p> <p>___ Occasionally incontinent</p> <p>___ Inappropriately incontinent</p> <p>___ On toileting schedule</p> <p>___ Usually incontinent</p> <p>___ Frequently incontinent</p> <p>___ Incontinent</p> <p>___ Catheter</p> <p>Comment: _____</p>														
<p>9. Identify level of assistance with the following</p> <p>0 = Independent 1 = Prompts/supervision 2 = On training program 3 = Assistance of 1 or 2 4 = Total assistance</p> <table><tr><td>___ A. Bathing</td><td>___ H. Treat own minor physical problems</td></tr><tr><td>___ B. Grooming</td><td>___ I. Use transportation</td></tr><tr><td>___ C. Toileting</td><td>___ J. Prepare meals</td></tr><tr><td>___ D. Dressing</td><td>___ K. Maintain an adequate diet</td></tr><tr><td>___ E. Medication administration</td><td>___ L. Respond to emergencies/ask for assistance</td></tr><tr><td>___ F. Use telephone</td><td>___ M. Manage financial affairs</td></tr><tr><td>___ G. Schedule own medical or mental health treatment</td><td>___ N. Mobility (ID Method/ability to use)</td></tr></table>		___ A. Bathing	___ H. Treat own minor physical problems	___ B. Grooming	___ I. Use transportation	___ C. Toileting	___ J. Prepare meals	___ D. Dressing	___ K. Maintain an adequate diet	___ E. Medication administration	___ L. Respond to emergencies/ask for assistance	___ F. Use telephone	___ M. Manage financial affairs	___ G. Schedule own medical or mental health treatment	___ N. Mobility (ID Method/ability to use)
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___ G. Schedule own medical or mental health treatment	___ N. Mobility (ID Method/ability to use)														
<p>10. Oral/nutritional</p> <p>___ No problems</p> <p>___ Weight loss/gain _____</p> <p>___ Other _____</p> <p>___ Special diet _____</p> <p>___ Fluid monitoring _____</p>	<p>11. Therapies</p> <p>___ None</p> <p>___ Physical</p> <p>___ Speech/language</p> <p>___ Occupational</p> <p>___ Audiological</p> <p>___ Other</p> <p>Frequency _____</p>														
<p>12. Special Treatments</p> <p>___ None</p> <p>___ Heparin lock</p> <p>___ IV fluids</p> <p>___ IV meds</p> <p>___ Transfusions</p> <p>___ Dialysis</p> <p>___ Suctioning</p> <p>___ Tracheostomy care</p> <p>___ Gastrostomy care</p> <p>___ NG tube</p> <p>___ Decubiti</p> <p>___ Aseptic dressing</p> <p>___ Respiratory treatment/oxygen therapy</p> <p>___ Diabetic monitoring</p> <p>___ Wound care</p> <p>___ Ileo/colostomy</p> <p>___ Catheter care</p> <p>___ Lung aspirations</p> <p>___ Other _____</p>	<p>13. Medical Conditions</p> <p>___ None</p> <p>___ Comatose</p> <p>___ Dizziness/vertigo</p> <p>___ Edema</p> <p>___ Fever</p> <p>___ Fractures</p> <p>___ Frequent falls</p> <p>___ Hypertension (controlled)</p> <p>___ Hypertension (uncontrolled)</p> <p>___ Hypotension</p> <p>___ Seizures (controlled)</p> <p>___ Seizures (uncontrolled) (specify frequency _____)</p> <p>___ Skin disorder</p> <p>___ Hypothyroidism</p> <p>___ Other _____</p> <p>___ Other _____</p>														
<p>14. Body control problems</p> <p>___ None</p> <p>___ Balance loss</p> <p>___ Unsteady gait</p> <p>___ Gait disturbance</p> <p>___ Loss of head or extremity control (specify) _____</p> <p>___ Other _____</p> <p>___ Contractures</p> <p>___ Paralysis</p> <p>___ Tremors</p> <p>___ Amputation</p>	<p>15. Restraint use</p> <p>___ None</p> <p>___ Bed rails</p> <p>___ Trunk restraint</p> <p>___ Limb restraint</p> <p>___ Geri chair</p> <p>___ Wander guard</p> <p>Frequency of above _____</p> <p>Purpose _____</p>														
<p>16. Medical status</p> <p>___ Condition/disease makes cognitive, ADL, or behavior status unstable</p> <p>___ Current acute episode of a recurrent/chronic condition</p> <p>___ Condition is stable ___ Condition is deteriorating</p>	<p>17. Lab values: Any abnormal lab values within the past 90 days?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____</p>														

Native:

[illegible]

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Name: _____

Section V: PSYCHIATRIC HISTORY

1. History of Psychiatric/Substance Abuse Hospitalizations

Facility	Date(s)	Diagnosis	Reason for Admission

2. History of Psychiatric/Substance Abuse Treatment

Facility	Date(s)	Diagnosis	Purpose of Treatment

3. Is There A Family History of Mental Illness or Substance Abuse?

☐ No ☐ Yes (If Yes, Specify Family Members and Diagnosis): _____

Section VI: PSYCHIATRIC EVALUATION/OBSERVATIONS (check all that apply); ELABORATE BELOW

1. Dress/Grooming <input type="checkbox"/> Neat <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriate	2. Attention <input type="checkbox"/> Adequate <input type="checkbox"/> Short <input type="checkbox"/> Distractible	3. Behaviors <input type="checkbox"/> Appropriate <input type="checkbox"/> Compulsive <input type="checkbox"/> Inappropriate	4. Suicidal Ideation <input type="checkbox"/> Not Present <input type="checkbox"/> Present * Explain below _____	Homicidal Ideation <input type="checkbox"/> Not Present <input type="checkbox"/> Present
5. Motor <input type="checkbox"/> Unremarkable <input type="checkbox"/> Posturing <input type="checkbox"/> Tics/Tremors <input type="checkbox"/> Restless	6. Mood <input type="checkbox"/> Level <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Labile	7. Affect <input type="checkbox"/> Appropriate <input type="checkbox"/> Flat <input type="checkbox"/> Blunted <input type="checkbox"/> Incongruent	8. Attitude <input type="checkbox"/> Cooperative <input type="checkbox"/> Oppositional <input type="checkbox"/> Agitated <input type="checkbox"/> Guarded	
9. Associations <input type="checkbox"/> Intact <input type="checkbox"/> Loose <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Circumstantial <input type="checkbox"/> Fragmented <input type="checkbox"/> Confabulation	10. Thought Content <input type="checkbox"/> Appropriate <input type="checkbox"/> Somatic <input type="checkbox"/> Preoccupied <input type="checkbox"/> Obsessive <input type="checkbox"/> Ruminations	11. Speech Form <input type="checkbox"/> Appropriate <input type="checkbox"/> Pressured <input type="checkbox"/> Slurred <input type="checkbox"/> Stutters <input type="checkbox"/> Blocking	12. Speech Content <input type="checkbox"/> Appropriate <input type="checkbox"/> Disorganized <input type="checkbox"/> Fragmented <input type="checkbox"/> Vague <input type="checkbox"/> Superficial	13. Thought Process <input type="checkbox"/> Goal directed <input type="checkbox"/> Easily distracted <input type="checkbox"/> Repetitive speech <input type="checkbox"/> Incoherent speech <input type="checkbox"/> Other _____
14. Hallucinations <input type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other Frequency _____ Have symptoms increased? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Delusions <input type="checkbox"/> None <input type="checkbox"/> Persecutory <input type="checkbox"/> Paranoid <input type="checkbox"/> Grandeur Frequency _____ Have symptoms increased? <input type="checkbox"/> Yes <input type="checkbox"/> No		

16. Describe presentation and mental status observations to include distinction regarding acuity vs chronicity of symptoms and whether symptoms are attributable to psychiatric condition or other causes (e.g. medications):

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17. Behavioral Assessment: Check any conditions present within the past 6 months. Circle appropriate codes adjacent to identified conditions.

Frequency: H = hourly W = weekly D = daily M = monthly				Severity: MI = mild S = severe MO = moderate				Status: I = improved/resolved O = deteriorated C = chronic N = no change			
Behavior	Frequency	Severity	Status	Behavior	Frequency	Severity	Status				
___ Sadness	H D W M	MI MO	S I C D N	___ Self-injurious	H D W M	MI MO	S I C D N				
___ Tearfulness	H D W M	MI MO	S I C D N	___ Physically aggressive	H D W M	MI MO	S I C D N				
___ Hopelessness	H D W M	MI MO	S I C D N	___ Verbally aggressive	H D W M	MI MO	S I C D N				
___ Worthlessness	H D W M	MI MO	S I C D N	___ Sexually aggressive	H D W M	MI MO	S I C D N				
___ Insomnia	H D W M	MI MO	S I C D N	___ Uncooperative	H D W M	MI MO	S I C D N				
___ Hypersomnia	H D W M	MI MO	S I C D N	___ Angry	H D W M	MI MO	S I C D N				
___ Grief	H D W M	MI MO	S I C D N	___ Abrasive	H D W M	MI MO	S I C D N				
___ Anxiety	H D W M	MI MO	S I C D N	___ PICA behavior	H D W M	MI MO	S I C D N				
___ Reclusiveness	H D W M	MI MO	S I C D N	___ Destructive	H D W M	MI MO	S I C D N				
___ Resistant	H D W M	MI MO	S I C D N	___ Disruptive	H D W M	MI MO	S I C D N				
___ Hoarding	H D W M	MI MO	S I C D N	___ Wandering	H D W M	MI MO	S I C D N				
___ Stealing	H D W M	MI MO	S I C D N	___ Confused	H D W M	MI MO	S I C D N				
___ Suicidal thoughts	H D W M	MI MO	S I C D N	___ Suspicious	H D W M	MI MO	S I C D N				
___ Homicidal thoughts	H D W M	MI MO	S I C D N	___ Medication refusal	H D W M	MI MO	S I C D N				
___ None of the above				___ None of the above							

18. Patient's impression of behavioral status (level of insight):

19. Describe interventions used for problem behaviors identified, as well as the degree of response to those interventions.

20. Socialization

- | | | | |
|---------------------------------|---------------------------------|---------------------------------|-------------------------------|
| ___ Active participant | ___ No interaction | ___ Resists interactions | ___ Socially inappropriate |
| ___ Passive participant | ___ Initiates interactions | ___ Habitually disruptive | ___ Socially appropriate only |
| ___ Interacts only with prompts | ___ Offers assistance to others | ___ Attends facility activities | ___ with prompts |

21. Safety: Is the individual currently dangerous to self or others? ☐ Yes ☐ No

Explain if yes _____

Section VII: SUMMARY OF PSYCHIATRIC TESTING

1. Modified Mini Mental Status (3MS) Total Score _____

Test Considered: ☐ Valid ☐ Invalid: _____

_____ <7th grade education _____ refused test items

_____ physically unable to _____ other _____

_____ complete test items

Pertinent Findings: _____

2. Other Testing: _____

Pertinent Findings: _____

Section VIII: SERVICE DELIVERY

1. Currently Receiving:

<input type="checkbox"/> Inpatient psychiatric treatment	<input type="checkbox"/> Individual or group counseling	<input type="checkbox"/> None
<input type="checkbox"/> Psychiatric consultation	<input type="checkbox"/> Psychotropic prescription monitoring by a psychiatrist	
<input type="checkbox"/> Psychotherapy	(specify frequency and last visit) _____	
<input type="checkbox"/> Day treatment	<input type="checkbox"/> Other mental health services _____	

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Section IX: INTERVIEW SUMMARY/OBSERVATIONS

Summarize recent behaviors and the intensity, nature and duration of presenting psychiatric problems

Section X: LEVEL OF DISABILITY/DURATION OF ILLNESS SUMMARY

1. List DSM-III-R or IV Axis I & Axis II Diagnoses of record:

2. Has the individual:

a) received psychiatric treatment more intensive than outpatient care more than once in the past two years (to include inpatient or partial psychiatric hospitalization)?

☐ No ☐ Yes (If yes, specify and include dates): _____

b) (within the past two years and DUE TO A MENTAL DISORDER) had an episode of significant disruption to the normal living situation which required supportive services to maintain functioning in that environment or which resulted in intervention by housing or law enforcement officials?

☐ No ☐ Yes (If yes, specify and include dates): _____

3. Has the individual exhibited limitations in age-appropriate roles (NOT RELATED TO PHYSICAL STATUS BUT BECAUSE OF PSYCHIATRIC DISORDER) in any of the following areas on a continuing or intermittent basis within the past six months:

a) **INTERPERSONAL FUNCTIONING** Serious difficulty interacting appropriately and communicating effectively with others. May have a history of altercations, evictions, firings, fear of strangers, or social isolation.

☐ No ☐ Yes (If yes, describe nature and frequency of behavior): _____

b) **CONCENTRATION PERSISTENCE PACE** Serious difficulty sustaining focused attention sufficient to complete tasks or unable to complete tasks within an established time period. Difficulties with concentration, makes frequent errors or requires assistance in completion of tasks?

☐ No ☐ Yes (If yes, please describe): _____

c) **ADAPTATION TO CHANGE** Serious difficulty in adapting to typical changes in circumstances. Manifests exacerbated psychiatric symptoms or withdrawal from the situation, or requires mental health or judicial intervention?

☐ No ☐ Yes (If yes, please describe): _____

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Section XI: SUMMARY

1. Diagnoses of Record

Axis I: Primary _____
 Secondary _____

Axis II: Primary _____
 Secondary _____

Axis III: (Medical) _____

2. Halted criteria:

___ Meets PASARR population - has a psychiatric condition which could lead to a chronic disability but is not a sole organic disorder or a primary diagnosis of dementia

___ Halted evaluation - does not have a chronic diagnosis; diagnosis is organic only, or has a primary diagnosis of dementia. If this block is checked, complete numbers 3 - 5 (fully explaining the reason for halting the assessment) and sign and date the assessment.

3. Summary of social and medical history (Include discussion of current medical and psychiatric status):

4. Strengths (Internal/environmental capabilities):

5. Weakness (Internal/environmental limitations):

6.A. Placement Recommendations:

☐ the individual meets minimum criteria for NF placement and nursing facility is the appropriate placement alternative (specify criteria codes met per Nebraska NF LOC worksheet) _____

☐ The individual's needs can only be met at Quality Living NF (specify criteria codes per LOC Worksheet) _____

☐ The individual is not appropriate for NF care

6.B. Rationale for placement recommendations:

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Name: _____

7. Service Recommendation:

- A. ☐ None, additional services not required
- B. ☐ The individual requires inpatient psychiatric treatment
- C. ☐ Recommend evaluation for the following services

<input type="checkbox"/> Ongoing medication review by a psychiatrist	<input type="checkbox"/> Visual evaluation
<input type="checkbox"/> Ongoing medication review by a physician	<input type="checkbox"/> Dental evaluation
<input type="checkbox"/> Neurological examination to substantiate organicity	<input type="checkbox"/> Audiological evaluation
<input type="checkbox"/> Speech/language therapy (circle one)	<input type="checkbox"/> Increase in stimulation/environmental enhancements
<input type="checkbox"/> Physical or Occupational (Circle One) Therapy	<input type="checkbox"/> Psychological/psychiatric evaluation
<input type="checkbox"/> Day program	<input type="checkbox"/> Behavior management program
<input type="checkbox"/> Vocational evaluation	<input type="checkbox"/> Alternative communication device
<input type="checkbox"/> Other _____	

Rationale _____

Evaluator Signature & Degree

Date

*For Preadmission assessments
attach and submit copies of:*

- 1) H & P Exam 4) Guardianship Cert.
2) DM-S-LTC or MDS 5) Social History
3) Release of Information

Evaluator Printed Name

Section XII: FMH USE ONLY — PROVISIONAL DIAGNOSTIC IMPRESSIONS

Axis I: Primary _____

Axis I: Secondary _____

Axis II: _____

Axis III: _____

FMH Validating Professional

Date

THE MODIFIED MINI MENTAL STATE (3MS)

ie _____ Rater _____ Date _____
day/month/year

3MS

DATE AND PLACE OF BIRTH

5 Place: Town _____ State _____

Date: Year _____ Mo _____ Day _____

REGISTRATION (No. of presentations)

3
Shirt, Brown, Homesty
(or: Shoes, Black, Modesty)
(or: Socks, Blue, Charity)

MENTAL REVERSAL

7
5 to 1
Accurate 2
1 or 2 errors/misrec 0 1
DELOW 1 2 3 4 5

FIRST RECALL

9
Spontaneous recall 3
After "something to wear" 2
"Shoes, Shirt, Socks" 0 1
Spontaneous recall 3
After "a color" 2
"Blue, Black, Brown" 0 1
Spontaneous recall 3
After "a good personal quality" 2
"Honesty, Charity, Modesty" 0 1

TEMPORAL ORIENTATION

15
Year
Accurate 8
Missed by 1 year 4
Missed by 2-5 years 0 2
Season
Accurate or within 1 month 0 1
Month
Accurate or within 5 days 2
Missed by 1 month 0 1
Day of Month
Accurate 3
Missed by 1 or 2 days 2
Missed by 3-5 days 0 1
Day of week
Accurate 0 1

SPATIAL ORIENTATION

5
State 0 2
Country 0 1
City (Town) 0 1
Hospital/office building/home 0 1

NAMING

5
Forehead _____ Chin _____ Shoulder _____
Elbow _____ Knuckle _____

FOUR-LEGGED ANIMALS (30 SECONDS) 1 PT EA

SIMILARITIES

Arm-Leg
Body part; limb; etc. 2
Less correct answer 0 1
Laughing-Crying
Feeling; Emotion 2
Other correct answer 0 1
Eating-Sleeping
Essential for life 2
Other correct answer 0 1

REPETITION

"I would like to go home/out" 2
1 or 2 missed/wrong words 0 1
"No ifs _____ Ands _____ or Buts _____" 3

READ AND OBEY "CLOSE YOUR EYES"

Obeys without prompting 3
Obeys after prompting 2
Reads aloud only 0 1
(spontaneously or by request)

WRITING (1 MINUTE)

Spontaneous Sentence or (if unable): (I) Would like to go on

COPYING TWO PENTAGONS (1 MINUTE)

	Each Pentagon	
5 approximately equal sides	4	4
5 unequal (> 2:1) sides	3	3
Other enclosed figure	2	2
2 or more lines	0 1	0 1
4 corners	Intersection	
Not - 4 corner enclosure	0	1

THREE-STAGE COMMAND

____ Take this paper with your left/right hand
____ Fold it in half, and
____ Hand it back to me

SECOND RECALL

(Something to wear)	0	1	2	3
(Color)	0	1	2	3
(Good personal quality)	0	1	2	3

CLOSE YOUR EYES

